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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 37 for an individualized toileting program until the facility care planned repeated falls and documented he should be toileted hourly. (Refer to F324 as it relates to additional findings for this resident regarding falls related to toileting without assistance). 6. Resident #9 had a Foley catheter inserted on 5/20/06. The catheter had since been discontinued. The care plan still contained an approach for a Foley catheter dated 5/24/06. There was also an undated temporary care plan for a Foley catheter in with the current care plan. It was not discontinued. The catheter had been discontinued on 6/28/06 as documented in a nurse progress note.	F 280		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility did not ensure a resident received physical assistance with eating. This affected 1 of 13 sample residents (#7). Findings include: Resident # 7 was admitted to the facility on 8/31/02 with diagnoses including dementia, hypertension, joint pain, lumbago, psychosis,	F 312	**F312 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** Resident (#7) was moved to a different table in the dining room to receive more assistance. **F312 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** Residents that require assistance with eating have the potential to be affected.	

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F 312	Continued From page 38 pulmonary congestion, glaucoma, atrial fibrillation, hypothyroidism, and anxiety. The resident was on a pureed diet. The resident's most recent MDS, dated 4/26/06, documented the resident required extensive physical assistance of one staff member for eating. The resident's care plan, dated 1/19/06, documented the resident had a self care deficit and one approach in reference to eating was, "(4) Requires up to supervision for eating. Needs verbal cues to stay on task." The resident was observed on 7/11/06 at 8:10 am. At that time, the resident was served breakfast and a CNA set it up for her. During a constant observation from 8:10 to 8:46 am, the resident was not observed to feed herself independently. The resident was cued to eat on a regular basis by a CNA and was observed to drink fluids independently. During the observation, the CNA made no attempt to feed the resident and the resident was not observed to consume any food from her tray. On 7/12/06 the resident was constantly observed from 7:55 to 8:28 am. The resident was served breakfast at 7:55 am but did not attempt to feed herself independently. The resident was observed to drink fluids independently. At 7:59 am, a CNA gave the resident a bite of eggs and a drink of milk and coached her to eat. The resident did not resist being fed but did not initiate feeding herself independently when coached to. At 8:06 am, the CNA fed the resident a bite of eggs and a bite of cereal. The resident independently drank from a	F 312	**F312 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** In-service all nursing staff on providing proper assistance with meals and reheating food when appropriate. Designee to ensure staff is providing necessary assistance with meal intake daily. DNS and dietary manager will review daily the designee's audits, and communicate the results to the different departments. **F312 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Review weekly at quality assurance meeting until resolved. After compliance will review as needed. Person Responsible: Melodie Jensen, RN DNS Cindy Broome, Dietary Manager Completion Date: August 18,2006 Ok, BF, 8/15/06	

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F 312	Continued From page 39	F 312		

glass containing a health shake and one containing milk. She made no attempt to feed herself. At 8:09 am, the CNA left the table and was relieved by another CNA. The new CNA cued and coached the resident to eat but the resident did not make an attempt to feed herself. At 8:25 am, the resident was seated at the table with her arms folded over her chest. The CNA again prompted her to eat. The CNA fed her a small bite of eggs but the resident made a face and did not ingest the food willingly. The CNA was not observed to feed the resident again or attempt to re-heat the resident's food.

The resident was observed on 7/12/06 at 12:05 pm sitting at a table in the dining room drinking a glass of water. The resident was constantly observed from 12:05 to 12:33 pm. Her lunch was served and set up at 12:14 pm. At 12:16, the resident was observed to be licking the top of a cup containing ice cream and drinking a glass of juice. The resident continued to lick the cup of ice cream and at 12:17, picked up her spoon and starting eating it. The resident steadily fed herself from the ice cream cup for approximately 6 or 7 minutes. At 12:28, the CNA prompted the resident to eat the other dessert on the tray. The CNA placed a spoon in the dessert and placed it in front of the resident. At 12:30, a LN leaned over the resident to encourage her to eat her entree. At 12:32, the resident took one bite of what appeared to be mashed potatoes. The resident received a new cup of ice cream at 12:33 and was observed to be feeding herself independently at that time.

An interview was conducted with the dietary manager on 7/13/06 at 9:35 am regarding the

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F 312	Continued From page 40 resident. She stated she had attempted to move the resident to a different table (where residents were being fed) but the resident did not want to move. She stated she had tried to feed the resident but the resident resisted. She stated she would attempt to move the resident to another table again and if the resident refused to move, CNAs would attempt to feed the resident at her current table.	F 312		
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review it was determined the facility did not implement measures to prevent skin break down on the coccyx and feet for 1 of 1 sample resident (#9). Findings include: 1. Resident #9 was admitted on 4/6/04 with diagnoses that included Parkinson's disease, diabetes and congestive heart failure. The resident went to the hospital for treatment of septicemia. She was readmitted to the facility on 2/9/06.	F 314	**F314 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** A foot cradle was placed on the bed of resident (#9). Care plan and resident care card updated. **F314 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents have the potential to be affected.	

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F 314	Continued From page 41 A significant change MDS assessment, dated 2/13/06, contained a RAP triggered for pressure ulcers which documented: "[Resident #9] is at risk for pressure ulcers due to impaired bed mobility, and occasional bowel incontinence. She has impaired sensation in her lower extremities 2nd to diabetic neuropathy. Does not have any current skin issues. Will proceed to care plan for prevention..." The resident's pressure ulcer risk assessment completed on 2/9/06 documented a score of 16 (15 - 18 at risk). This was upon her return from the hospital. On 5/10/06 her pressure ulcer risk assessment documented that her score was a 12 (10 - 12 = high risk). The following documentation was in the nurse progress notes: 2/9/06, (11:30 am)- "Pressure relieving cushion w/chair [wheel chair], pressure rel[ieving] mattress bed." 3/3/06, (10:40 am)- "Resident is turned/repositioned [every] hr. Coccyx & heels look good @ this time..." 3/17/06, (9:30 pm)- "Pt. [Patient] has open abrasion to Lt [left] buttocks gluteal fold. Pt. turned every hour, area covered [with] moisture berrier [sic]." 3/18/06, (6:00 am)- ...Res[ident] turned & repositioned [every] 2 hours this shift. Heels supported with pillows. Moisture barrier cream applied to peri-rectal area per episodes. Res denied pain at this time... (9:00 pm)- "... Pt on Lt side off buttocks area moisture berrier [sic] applied to area open on buttocks." 3/19/06, (8:00 pm)- "... Pt buttock cont[inues] to	F 314	**F314 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** In-service all staff on prevention of skin break down. Treatment nurse to audit all residents that have scores less than, or equal to 12 on the pressure ulcer risk assessment, and reassess that the proper interventions are used. The information will be transferred to the resident care card and medication record to ensure preventive measures are in place. **F314 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Review weekly at quality assurance meeting until compliant. After compliance will review as quarterly and as needed. Person Responsible: Melodie Jensen, RN DNS Connie Graft, LPN Treatment Nurse Completion Date: August 18,2006 OK. BF, 8/15/06	

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F 314	Continued From page 42 be open. Pt turned with pillows D/T [increased] pain to legs during reposition..." 3/22/06, (8:30 am)- "Inzo cream to L[eft] buttock cheek scratch [every] shift & prn [as needed] x 10 days." 3/24/06- A weekly summary nurse note documented, "...L buttock area to have Inzo cream [every] shift & prn. Tx [Treatment] nurse to follow care." 4/6/06, (4:35 am)- "Turned and repositioned [every] 2 [illegible]...Heels [elevated] & supported with pillows..." 4/10/06, (9:00 am)- "N.O. [New Order] written for Bacitracin & Band-Aid to top of Rt foot [change] every day till healed. 4/12/06, (2:00 am)- "...Turned and position bilat LE [bilateral lower extremities elevated] & supported with pillows..." 4/14/06- A weekly summary nurse note documented, "Scrape to top of R[ight] foot- TX nurse to follow care, area to buttocks [with] drsg [dressing]." 4/17/06, (1:10 pm)- "... Res was reported this AM to have an abrasion to R heel. Foot [elevated] on pillows. Unknown what cause was." (8:00 pm)- "Pt has been turned frequently D/T open area on buttocks. Pt turns self back to back...Area on heel blanchable, legs floated to keep heels off sheets." 4/19/06, (8:10 am)- "N.O. DC [Discontinue] occlusion dressing to buttock...Posey boot to both feet in bed as resident will allow." 4/28/06, (2:00 pm)- "DC Poop Goop to buttock, apply soloside gel & allevyn thin to buttock, [change] at least 2x's a week..."5/4/06, (illegible)- "DC flair care mattress bed, apply primary air mattress bed- pressure relief. DC Posey boots adamantly refuses to wear.(Allevyn regular to buttock.)"	F 314		

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F 314	Continued From page 43 5/1/06, (12:00 pm)- "Resident is resistant to floating heals. R heel is pink, tender but blanchable. Will initiate Posey boots again, very resistant to floating heels." 5/31/06, (5:00 pm)- "Resident continues on Clindamycin for R toe infection..." 6/1/06, (4:00 am)- "...R toe infection...Posey boots in place to bilat [lower extremities]. Turned and reposition. Poop Goop to coccyx area applied per episode..." 6/3/06, (8:30 pm)- "Bandage to toe [changed] this eve [with] open wound noted. Scant yellow drainage [with] yellow covered opened area on distal knuckle of toe. Area surrounding wound is red & irritated..." 6/15/06, (1:00 p,)- DC bacitrain & bandaide to top of R foot, healed." 6/28/06, (5:00 pm)- "...Peri rectal area is completely healed [with] Poop Goop." The following observation were completed for resident #9: 7/10/06, 2:40 pm- In bed, lying on her back. 7/11/06, 8:40 am- Had been removed from dining room (Refer to F514 for additional findings regarding resident illness with lack of documentation) and in her room seated in her wheel chair with an emesis pan. At 9:15 am, she was still sitting in the wheel chair in her room. She had Posey boots on both feet and her feet were up on a chair in her room. At 10:55 am she was in her bed on her back. At 12:50 pm she was in the dining room seated in her wheel chair. At 2:00 pm she was in her room seated in her wheel chair and asleep. At 2:55 pm, an aide was in her room. The resident was still up in the wheel chair. The aide said, "I'm getting ready to lay her down. She wants to rest."	F 314		

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F 314	Continued From page 44 7/12/06, 6:15 am- The resident was asleep in her bed on her back. It was not possible to see if her Posey boots were on. There was no foot cradle at the end of the bed to keep the covers from rubbing her toes. At 6:55 am the resident was in the same position. The resident was observed for ADL care at 7:38 am. The aides pulled a pillow out from under her buttocks. They indicated they try to keep it on one side to keep her off her buttocks. Staff performed incontinence care. They were asked how the resident's bottom looked. They said it was good and without redness or breakdown. The surveyor requested to look at her heels. The aide pressed on the heels and they blanched easily. The heels were clear of any open areas. The resident had a Band-Aid covering the second toe of her right foot. This was sensitive as she winced when the aides put her ted hose on. There was no foot cradle on the bed. The Posey boots were placed on the resident after she was dressed and in her wheel chair. At 8:02 am, she was in the dining room seated in her wheel chair. At 10:30 am, the resident was still up in her wheel chair. She was in her room and had her feet propped up on a chair. Her head was hanging forward and she was asleep. At 12:15 pm, she was seated in her wheel chair in the dining room. Most of the time when this resident was observed she was either sitting in her wheel chair or in her bed on her back. This positioning put pressure on her coccyx which had a recently healed sore. Being in bed with her toes pointed up also put pressure on her toes and risk for shearing as she did not have a foot cradle on her bed to keep the covers off her toes. During interviews with the wound nurse on	F 314		

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F 314	Continued From page 45 7/13/06 at 10:05 am, she disagreed that the wounds the resident were pressure ulcers. She indicated they were not over bony prominences. There was some discussion by the surveyor regarding shearing and maceration also causing pressure sores. The wound treatment nurse said, "I don't consider that a pressure ulcer." Skin condition reports did not contain meaningful information as the wounds were considered scrapes or abrasions and so were not staged or measured. The facility noted the resident had an abrasion to the coccyx area on 3/17/06. There was no indication the resident was placed on an air mattress until 4/2/06. The resident was noted to have red heels on 5/1/06 because she was resistant to having her heels floated. Posey boots were initiated then. There was no care plan that documented the resident had these resistive behavior symptoms. The facility did not ensure preventative plans were in place for a resident at high risk for pressure sores.	F 314		
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observations and a staff interview, it was determined the facility did not ensure that 1 of 8 tub/shower rooms were secured to prevent slip/trip/falling on the wet floor or ingesting personal hygiene chemicals. This affected all	F 323	**F323 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** Maintenance immediately fixed the door. All potentially hazardous chemicals were safely stored.	

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F 323	Continued From page 46 ambulatory, cognitively impaired residents on the 300 hallway. The findings include: On 7/11/06 at approximately 1:45 pm, the door to the 300 hallway shower room was observed to be open. The shower room was unattended and their was water on the floor. The maintenance man stated, "oh, it's supposed to be closed." When fully closed, the door was locked and not accessible to residents. The maintenance man concurred the shower room was supposed to be locked. The floor of the shower was covered with water creating a slip/trip/fall hazard. On the shelf in the shower, located approximately 5 feet from the floor level, was an 8 ounce plastic bottle of apple/strawberry scented shampoo/body wash. There was approximately 4 ounces of shampoo/body wash remaining in the bottle. On 7/12/06 at 6:50 am, the door to the 300 hall shower room was observed to be open. The shower room was unattended. When pushed shut, the door would lock. On 7/13/06 at approximately 12:10 pm, the administrator was told about the 300 hall shower room door being open a second time on 7/12/06.	F 323	**F323 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents have the potential of being affected. **F323 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** All staff in-serviced regarding the potential danger from not closing shower room doors tightly. Also on keeping all hazardous chemicals properly stored. Maintenance director will do weekly round to ensure compliance. **F323 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Review weekly at quality assurance meeting until compliant. Also, reviewed monthly at safety meeting. Person Responsible: Boyd Stokes, Maintenance Director Completion Date: August 18,2006 OK. BF. 8/14/06	

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F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility incident/accident reports and record review, it was determined the facility failed to prevent falls and skin tears of unknown origin for 3 of 16 sample residents (#4, 9 and 13) evaluated for such injuries. Findings include: 1. Resident #4 was admitted to the facility on 5/5/05 with diagnoses of dementia, agitation, mitral valve disorder and edema. A fall risk assessment was completed for the resident on 5/5/06 which resulted in a score of 12 (10 or above = High Risk). The resident's quarterly MDS assessment, dated 2/25/06 and his annual MDS, dated 5/10/06, both documented moderate cognitive impairment and that he had fallen in the last 30 days and the last 31- 180 days. The following documentation was contained in the facility incident/accident reports: 5/18/05, (7:35 am)- "...Bruise 5 cm x 2 cm x 0.1 cm Location to R[ight] side of face... Resident is non compliant with using walker/calling for assistance to use BR [bath room]. Resident took self to BR & did not use walker. The fall was unwitnessed... Recommendations... Keep light on at all times in BR. Maintenance to place transfer bars in BR/Room. Toilet schedule - [7:00 am]...	F 324	**F324 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** Resident (#4) a new seven-day assessment was completed to establish a voiding pattern accompanied with an individualized toileting schedule. Resident (#9) a new MDS and a seven-day bowel and bladder assessment were completed. It was accompanied with a individualized toileting schedule. Resident (#13) had her side rail evaluated for proper padding to ensure safety. These incidents occurred in the past and no further investigation could be done. **F324 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents have potential to be affected that have had incidents.	

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F 324	Continued From page 48 Pressure alarms to bed..." 5/24/05, (2:00 pm)- " ...fx [fracture] L[eft] wrist... Resident states he was at sink & lost his balance & fell putting his weight on L arm. Alarm was not sounding on bed & resident was at sink... Recommendations... Merry Walker [sic] implemented. Pressure alarms in bed & w/c [wheel chair]. Remind resident to use call light." 10/26/05, (10:00 am)- "...Resident was trying to put his lap buddy back on and slid out of his wheelchair sliding down the wall on his L[eft] side. This was in the DR hallway by the TV room...alarm was not turned on & did not sound on lapbuddy [sic]. Res[ident] was wet d/t urine... Recommendations ...d/t res alarming lap buddy he's to be toileted [every 2 hours and prn] & repositioned in w/c. Continue lap buddy & alarm in w/c. monitor resident for agitation- res has hx [history] of needing to go to the bathroom when he's acting agitated. Make sure alarm is turned on when resident is placed in w/c..." The care plan was revised the same day and included the recommendations as new approaches for a fall risk. 11/11/05, (9:00 pm)- "...Skin tear R hand...1 cm...Res had successful fall from hi-lo bed onto mat/pad on floor... Recommendations... Continue hi-lo bed [with] pad on floor. Continue pressure alarms..." The care plan was revised the same day with the recommendations added as approaches. 11/17/05, (2:50 pm)- "...[No] injury...Res in TV room sitting in w/c [wheel chair]. He removed his lap buddy, sounding alarm & stood up [without]	F 324	**F324 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** All nursing staff was in-serviced on proper investigation of accidents and incidents. The in-service will cover the importance of interviews, investigation process, and reporting the incident. Accidents and incidents will be reviewed each business day by the interdisciplinary team to determine the cause and need for further investigation. All accidents and incidents will be reviewed weekly for completeness of investigation by the accident and incident team. Accidents and incidents investigation protocol will be part of the orientation process. A yearly in-service about abuse will be also be done by the facility.	

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F 324	Continued From page 49 assistance. Nrg [Nursing] rushed to res but he fell before help received [sic]... Recommendations... DC'd [Discontinued] w/c alarm & lap buddy. Res now in Merri Walker to promote independence, d/t [due to] dementia. Check res[ident] every 30 minutes. Remove from Merri Walker every 2 hours to toilet & reposition..." The care plan was revised the same day with the recommendations added as approaches. 11/21/05, (2:10 pm)- " [No] injury...Res found by CNA [name] on the floor @ [at] end of 300 hall under Merri Walker, foot caught in strap-poss[ibly] trying to crawl out of Merri Walker. Walker was upright and functioning..." A written statement from staff (discipline not indicated) contained the following documentation: "I [name] was told that resident was in another residents [sic] room. I went down the hallway and found resident on the floor. The Merrywalker [sic] was hooked up and residents [sic] foot was wrapped on the strap. The nurse came and helped me get him up... Recommendations... Staff to toilet resident every hour while awake & prn [as needed] during NOC [night] shift rounds. Therapy to place weights on Merri Walker so it doesn't tip & so it doesn't go to fast. Continue to check resident every 30 minutes..." The care plan was revised the same day with the recommendations added as approaches. 11/26/05, (5:55 pm)- "...abrasion R[ight] shoulder, bump to head...Res was in the assisted dining room, sitting in a regular chair. While staff serving trays, [resident #4] stood up & fell...hitting right elbow then the back of his head 5 cm edematous area skin intact... Recommendations... Staff not to transfer him out of w/c with lap buddy & into	F 324	**F324 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Review weekly at quality assurance meeting. Person Responsible: Melodie Jensen, RN DNS or appointed designee. Completion Date: August 18,2006 OK, BF, 8/15/06	

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F 324	Continued From page 50	F 324		

regular chair, until they are finished serving meals & res ready to eat. Continue all other present interventions." The new intervention regarding supervision in the dining room was not added to the care plan until 12/6/05.

12/5/05, (5:00 pm)- "[No] injury...Res climbed out of merri-walker [sic], did not fall & did not receive an injury...Resident in dining room in Merry Walker [sic] found on hands and knees outside of Merry Walker. CNA's reported he did not fall extended leg across strap and crawled out. [No] injury alert to person... Recommendations... Res to be alternated between Merri Walker and w/c [wheel chair] lap buddy, every few hours. Res to be checked on every 30 min, removed & toileted every 1-2 hours. If res appears tired/sleepy, staff to lay him down for a nap. Do not leave resident in dining room, unattended..." The care plan was revised on 12/6/05 with recommendations added as approaches.

12/11/05, (4:00 am)- "Abrasion to L[eft] knee...Heard alarm- found resident [with] feet on mat beside bed [and] L buttock & L hip on floor & head & L shoulder on Merrywalker [sic]. Denied hitting head & pain...resident taken to toilet [with] assist 2 persons- was incontinent of BM... Recommendations ... Continue with pressure alarms. Continue with hi-lo bed with mat on floor (bed to be kept in low position). Continue to toilet resident frequently. Continue to monitor resident frequently. The care plan was revised on 12/23/05 with the recommendations added as approaches.

4/18/06, (10:30 am)- "...Nursing student reported res was sitting on floor in room merrywalker [sic]

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F 324	Continued From page 51 was in front of res, bar was unlatched & open res alert per usual, [no] injury noted...He unlatched the merri-walker [sic] & got out, attempted to get self into bed, but fell. He c/o [complains of] some knee pain, but [no] injuries present... Recommendations... Res is not to be left unattended (out of staff observance) in Merri Walker. Res must be visible... Staff to offer to lay res down for a nap between meals & prn. Staff to follow toileting program/schedule. Staff to make sure to check latch frequently- to make sure it's latched (he is able to unlatch it)- on Merri Walker... " The recommendations were care planned on 4/19/06 as a revision to the care plan for falls. The resident was observed on 7/11/06 at 2:45 pm, using a Merri Walker to ambulate. Two staff were with him by his door. No offer to use the toilet was made by staff. He went into his room and opened the bathroom door. He put the light on and removed the bar enclosing the Merri Walker. He then self toileted. On 7/12 at 6:38, the resident was in his room in the bathroom (door left open), independently toileting, with his Merri Walker out by the door. A CNA came up the hall and was entering the room. The surveyor asked if she had put him in the bath room. She stated, "No. He did it himself. He is one of them we can't keep tabs on some times." He again went into his room, while using his Merri Walker at 11:00 am. He parked the Merri Walker in front of the bathroom door, opened the latch and independently toileted. He was observed later at 3:05 pm, seated in his Merri Walker in the hall way next to his room, no staff were in the hall. He was not in line of sight of staff or being supervised.	F 324		

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F 324	Continued From page 52 During meals on 7/12/06 at 8:52 am. He was already seated in a dining room chair waiting for his meal. Staff were still serving and still leaving the dining room and then returning with residents being transported in wheel chairs. This was the case later at 12:30 pm during the lunch meal and on 7/13/06 at 8:25 am during breakfast service. On 7/13/06 at 9:35 am, staff including the DON, ADON [Assist DON] and the MDS LN met with the surveyor. They agreed that many of the resident's falls had revolved around his toileting needs. (Refer to F272 for additional findings related to incontinence assessments for individualized toileting needs). They confirmed that the resident was able to remove his Merri Walker latching bar and get out. They indicated he was supposed to be in line of sight when using the Merri Walker. The resident had a history of falls as evidenced by incidents of falls on 5/18 and 5/24/05 shortly after he was admitted on 5/5/05. He fractured his wrist when he fell on 5/24/05. On 10/26/05 his alarm was not activated and he was wet. On 11/21/05 the resident fell while not being supervised and had been in another resident's room. On 12/0/05 he was left in the dining room unsupervised and climbed out of the Merri Walker and was found on his hands and knees. The resident was not being supervised by keeping him in line of sight when he was in the Merri Walker. Nor were approaches implemented, to ensure he stayed in his wheel chair, with a lap buddy, until staff were able to supervise while he was in the dining room.	F 324		

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F 324	Continued From page 53 2. Resident #9 was admitted on 4/6/04 with diagnoses that included Parkinson's disease, diabetes and congestive heart failure. The resident's quarterly MDS, dated 5/18/06, documented moderate cognitive impairment and no falls. The following documentation was contained in the facility incident/accident reports: 1/10/06, (11:30 pm)- "... [No] injury... Res attempting to toilet self during night & didn't quite make it all the way to bathroom & set down on floor to prevent falling & prevent injury... Recommendations... Use of call light strongly encouraged. Assist res/pt [patient] to go/use the BR [every] 2 hours (at night). Staff to make sure res. call light in reach." This information was obtained by resident interview as the fall was not witnessed. The current care plan identified (3/1/06) "Self care deficit, risk for falls R/T [related to] DX [diagnoses] Parkinson's... Approaches ... Place call light within reach and instruct [resident #9] in use of call light...does not always use call light. Needs often need to be anticipated." 3/18/06, (10:00 pm)- "...Pt [atient] presents indented area to upper Rt [right] thigh area expands outer side of Rt thigh. Has Lt [light] green bruise starting to area. Pt is in pain during movement of Rt thigh..." A written statement from staff documented, "Checked in on [resident #9] before shift change. Upon removing her blankets I noticed an indention [sic] on her right lateral femur. When I moved her leg to see if she was dry, she expressed pain. A small amount of pain is usual for this patient but the way she yelled	F 324		

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F 324	Continued From page 54 when I moved her leg concerned me so I alerted my nurse at once." The form for administrative review documented, "Not due to injury." There was no way for the facility to know this at the onset of the injury. (Refer to F225 for additional findings related to lack of thorough investigations). The form documented the resident would see a doctor on 3/22/06. Review of the her physician's notes, dated 6/28/06, confirmed she had seen a specialist who reported a torn muscle. The resident had a diagnosis of muscle atrophy. There was no cause for the injury documented in the physician notes. The most current approach to her care plan was dated 5/5/06 and documented, "Hi-low bed [with] pad on floor keep in low position, res @ risk for falling d/t Parkinson's." The plan to prevent a fall by asking a cognitively impaired resident to use her call light was not realistic. A pressure alarm had been initiated on 4/25/06 for a care plan revision but discontinued on 5/5/06. The high-low bed with a mat was then initiated. This was well after the resident received a torn muscle to her thigh on 3/18/06. The facility did not adequately investigate for cause there by not assessing a way to prevent further injuries of unknown origin. 3. Resident #13 was admitted to the facility on 3/13/05 with diagnoses of Alzheimer's disease, esophogeal reflux, vision loss, constipation, anxiety, psychosis, general pain, Parkinson's disease, after care for hip fracture and behavioral symptoms. The resident's quarterly MDS, dated 5/17/06, documented she was severely cognitively	F 324		

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F 324	Continued From page 55 impaired and needed total assistance for transfers. She had not had a recent fall. The following documentation was contained in the facility incident/accident reports: 4/17/06, [7:35 am]- "... Scratch to face ... Resident was found to have a 3/6 cm scratch to R[ight] [lower] cheek. Unknown origin. Looked old when found ...CNA stated it wasn't there Saturday on day shift." (The prior Saturday would have been the 15th). "...Recommendation... Keep res nails trimmed & clean - free from sharp edges as able [with] zippers- so skin not scratched. Staff to encourage res to wear her gloves, as she will allow." These recommendations were care planned on 4/18/06. 4/23/06, (3:45 pm)- "...Skin tear R[ight] elbow ... found to have a skin tear present to R elbow when staff getting this res up for dinner. Her geri-arms were not on res (in bed) when skin tear found. Probably occurred while placing res into bed for nap... Recommendations... Staff to be gentle with cares/dressing/transfers d/t [due to] fragile skin. Make sure res has her geri-arms on during the day- for protection." 5/5/06, (3:10 pm)- "...Bruise L[eft] arm ... Res found to have a bruise to LFA [left fore arm]- probably occurred d/t [due to] bumping it on 1/2 SR [side rail], while in bed... Recommendations... pad 1/2 SR's [side rails] to help prevent injury while in bed." This was care planned on 5/8/06. 5/19/06, (6:30 am)- " ...Skin tear to LFA ... 6 cm x 1/2 cm- Bumped arm on side rail where rails meet top rail..." On another part of the form	F 324		

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F 324	Continued From page 56 documentation indicated this was the "probable cause." There was one staff statement documented, "I [name] was getting -[resident #13] dressed to get out of bed. I rolled her on her L side then went to roll her to her R side to stand up and noticed the skin tear..." The final conclusion was that the resident probably bumped her arm on the side rail. "...Recommendations... check 1/2 Sr's to make sure the padding is adequate & appropriately placed. Continue to wear geri-gloves and/or long sleeves..." 6/30/06, (2:50 pm)- "... Skin tear RFA ... Resident cognitively unaware of how incident occurred- staff states while doing cares they observed dried blood & skin tear had already happened... Recommendations ...Staff education to be more careful with cares... Long sleeves if possible... Make sure padding on side rails is adequate. Make sure res nails trimmed & cleaned." The facility failed to prevent skin tears of unknown origin for resident #13. The resident was observed on 7/13/06 at 10:25 am. She was in bed with two 3/4 side rails up. There were tie on pads attached to the side rails. The right side rail had the pad wrapped around to the outer side where it did not extend down as the side rail was not a full length. The facility did not determine actual cause for the skin tears. (Refer to F225 for findings related to lack of thorough investigation). This hampered their ability to plan new interventions to prevent recurrent skin tears.	F 324		

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F 366 SS=D	483.35(d)(4) FOOD Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, it was determined that the facility did not provide the resident dietary meal substitutes of similar nutritive value when the resident refused food that was served. This affected 1 of 13 sampled residents (#1). The findings include: Resident #1 was admitted to the facility on 08/31/04 with diagnoses including osteoporosis, back lumbago, hypothyroidism and anxiety nos [not otherwise specified]. Dietary progress notes dated 4/07/06 documented, "...PO [by mouth] is b [breakfast] 23%, l [lunch] 18%, d [dinner] 20%...PO intake continues to be poor." The care plan dated 4/24/06, documented a problem area as, 'Nutritional Status Care Plan.' Problems identified included: "less than 90% IWR [ideal weight]/less than 19 BMI [Body Mass}; leaving 25% + [plus] at most meals; Poor intake less than 50%." Approaches included: monitor daily intakes; supplement as ordered. Supplement TID [three times per day] and novasource 4 oz with meds [medications]." On 7/11/06 from 8:10 am until 8:35 am, resident #1 was observed during the breakfast meal. Resident #1 consumed approximately 25% of her meal. Staff asked her if she was through eating	F 366	**F366 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** An in-service was done immediately verbally to all present staff on offering alternatives to residents when they eat 50% or less of their meal. **F366 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents have the potential to be affected. **F366 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** In-service all staff on proper documentation of meal intake, and the importance of offering alternatives when eating less that 50% of their meal. Nurse supervisor to monitor residents at mealtime and ensure that residents are being offered an alternative if eating less than 50% of their meal. Also ensure that documentation is complete.	

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F 366	Continued From page 58 when they wheeled her from the table and did not offer a replacement meal to her even though she had consumed less than 75% of her breakfast. On 7/12/06 from 8:00 am until approximately 8:30 am, resident #1 was observed during the breakfast meal. Resident #1 consumed approximately 25% of her meal. Staff at no time were observed to offer resident #1 the alternative even though she consumed less than 75% of her breakfast. The Meal Intake Record documented: "Alternate: A=Alternate Accepted; R=Alternate Refused. *Offer alternate if resident eats <75% [less than] and report to charge nurse." The Meal Intake Record for May, June and July 2006, were reviewed for resident #1. *The month of May resident #1 had 43 of 93 meals she ate where she consumed less than 75% of her meal and she was not offered a meal replacement. Resident #1 consumed some of the alternate when offered to her on 27 of the 47 times it was offered to her during the month of May. *The month of June resident #1 had 58 of 90 meals she ate where she consumed less than 75% of her meal and she was not offered a meal replacement. Resident #1 consumed some of the alternate when offered to her on 20 of the 31 times it was offered to her during the month of June. *The month of July resident #1 had 15 of 32 meals she ate where she consumed less than 75% of her meal and she was not offered a meal replacement. Resident #1 consumed some of the alternate when offered to her on 15 of the 16	F 366	**F366 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Review weekly at nutrition meeting and report to the quality assurance committee monthly until compliant. Review as needed after compliance. Person Responsible: Melodie Jensen, RN DNS Cindy Brome, Dietary Manager or appointed designee. Completion Date: August 18,2006 OK, BF, 8/15/06	

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F 366	Continued From page 59 times it was offered to her during the month of July. On 7/12/06 at approximately 10:45 am, a staff interview was conducted with the dietary manager and registered dietician regarding resident #1's eating patterns. They both agreed that resident #1 has a history of having poor intake during meals. They stated that resident #1 is part of the facility SNP [special nutrition program] as a result of her poor intake. Residents that are included in the SNP received dietary supplements such as novasource. They both stated that with the supplements that resident #1 receives she is able to meet her dietary intake needs. They could not answer why the Meal Intake Record was not consistently completed regarding the offering of alternative meals to resident #1. When the surveyor inquired if it would be better for resident #1 to meet her dietary needs by engaging in eating her meals or alternative meals in the dining room they both stated that yes it would be. The facility failed to consistently offer resident #1 alternative meals even though she consumed less than 75% of her meals and had shown by history that she would eat them if given to her.	F 366		
F 369 SS=D	483.35(g) DIETARY SERVICES - ASSISTIVE DEVICES The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by:	F 369	**F369 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** Resident (#1) was re-evaluated by the Occupational Therapist for the need of assistive devices for eating, and how appropriate for self-feeding.	

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F 369	Continued From page 60 Based on observation, staff interview and record review it was determined the facility failed to ensure 1 of 2 sample residents (#9) who required assistive devices for eating were provided devices to meet the assessed need. Findings include: Resident #9 was admitted on 4/6/04 with diagnoses that included Parkinson's disease, diabetes and congestive heart failure. The resident went to the hospital for treatment of septicemia. She was readmitted to the facility on 2/9/06. The resident's most quarterly MDS, dated 5/18/06, documented moderate cognitive impairment, and needed limited assistance for eating. The resident was observed during meals on 7/12/06 at 8:02 am. She was seated at an assist, horse shoe shaped table. She was attempting to feed herself. She was managing fairly well but had a distinct tremor to her hand which made it difficult for her to load her fork and get it to her mouth without spilling her food. She did not use any kind of adaptive devices, such as weighted utensils or a plate guard. She was observed again during the lunch meal at 12:30 pm. This time she was not doing as well with self feeding and staff were assisting her to eat. The DON, Administrator and Dietary Manager were all present for an interview on 7/13/06 at 10:00 am. The surveyor stated to the staff that resident #9 was noted to have visible tremors, perhaps due to her Parkinson's diagnosis. The staff were asked, by the surveyor, if she needed	F 369	**F369 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents have the potential to be affected. **F369 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** The dietary manager will ensure all residents have been screened by the Occupational Therapists upon admission and change of condition. Occupational Therapy will notify the dietary manager of any changes that need to be made. **F369 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Review weekly at quality assurance meeting until compliant. After compliant this will be review as need. Person Responsible: Cindy Broome, Dietary Manager Occupational Therapist Completion Date: August 18,2006 OK, BF, 8\15\06	

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F 369	Continued From page 61 any assistive devices, such as weighted eating utensils or a plate guard. The dietary manager stated that the resident had devices before going to the hospital. When the resident returned the Dietary Manager indicated she had requested a new order from Occupational Therapy, but never received one. She said she did not follow up to determine if the resident still needed the devices. The facility did not provide assistive devices for resident #9 in order to help her maintain her independence to eat.	F 369		
F 431 SS=D	483.60(d) LABELING OF DRUGS AND BIOLOGICALS Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility did not ensure that in the 1 of 1 locked medication room, that 2 multidose vials were dated after opening and did not discard a third outdated multidose vial. This affected residents who received medication from the 3 multidose vials. The findings include: Page 3.29 of the facility policy, "Ordering and Receiving Medications from the Pharmacy," revised on 10/01/03, stated, "6. Medication labels	F 431	**F431 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** The affected medications were destroyed or disposed. **F431 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents have the potential to be affected.	

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F 431	Continued From page 62 are not altered, modified, or marked in any way by nursing personnel except for noting the date of opening a container (i.e. eye drops), in the case of time dated products..." Page 7.25 of the facility policy, "Expiration Dating and Document Requirements," revised June of 2005, indicated that the suggested expiration dates for multidose injection vials was 30 days. On 7/11/06 at 1:55 pm, 3 multidose vials were observed in the wood cupboard, above the counter top, in the locked medication room. All 3 had been opened but only one was dated. Next to the counter was the medication refrigerator with a sign that stated, "...Remember to Check Expiration Dates and Rotate Supplies." A 30 milliliter (ml) multidose vial of 0.9% sodium chloride was dated 5/12/06. Approximately 15 mls remained in the multidose vial. Two 20 ml multidose vials of 1% Lidocaine were not dated as to when they had been opened. One multidose vial had approximately 10 mls remaining and the other had approximately 15 mls remaining in the vial. A LN was asked if she knew when the Lidocaine had been opened, she stated, "I don't know." On 7/12/06 at 2:22 pm, the DON was told about the multidose vials. She stated, "I'm surprised, the pharmacy was just here."	F 431	**F431 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** In-service of all licensed staff on the importance of dating open medication, and disposing of out dated medication. Weekly audits of the medication room and medication charts will be done by DNS, or designee to ensure that all open medication is dated and outdated medication is disposed. **F431 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Review weekly at quality assurance meeting until compliant. Person Responsible: Melodie Jensen, RN DNS and or appointed designee. Completion Date: August 18,2006 OK, BF, 8/15/06	

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F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined that staff did not wash her hands after incontinence care and before doing other ADL care for 1 of 13 sample residents (#9) who was observed for ADL care. Findings include: Resident #9 was observed on 7/12/06 at 7:38 am, while being assisted with ADL care. The resident was assisted by two CNAs who came into the room, washed their hands and donned latex gloves. The resident was provided incontinence care while she was still in bed. Soiled items and latex gloves were bagged and placed on the floor. The aides put pink slacks on the resident and pulled them up when they assisted her out of bed and into her wheel chair. After the resident was fully dressed, she was taken over to the sink where her face was washed by a CNA. The same CNA got the toothpaste on the resident's toothbrush and handed it to her. The resident then brushed her teeth. The CNA combed the resident's hair and put some perfume on the resident. The CNA had not been observed to wash her hands after assisting with incontinence care and removing her gloves. She was then asked if she had washed her hands before providing the other ADL hygiene care. She indicated she had not.	F 444	**F444 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** Staff member identified was counseled and in-service, and demonstrated the skills that were in-serviced. **F444 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents have the potential to be affected **F444 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** In-service all staff on infection control associated with proper hand washing. Hand washing has been added to the orientation process and yearly infection control in-service. Appointed designee will do random audits with staff on proper hand washing techniques.	

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F 444	Continued From page 64 The facility did not follow standards of practice for hand washing after resident contacts, which could result in the spread of infection.	F 444	**F444 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** All new orientation packets will be reviewed ensuring that the hand washing in-service has been completed. Will review at quality assurance meeting until compliant. After compliance it will be reviewed as needed. Person Responsible: Melodie Jensen, RN DNS and or appointed designee. Completion Date: August 18,2006 OK, BF. 8/15/06 **F445 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** The linen was immediately picked up and removed from the room and taken to the laundry department. **F445 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents have the potential to be affected. **F445 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;**	
F 445 SS=D	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations it was determined the facility did not ensure that 1 of 5 linen rooms had clean laundry properly stored to ensure appropriate infection control. The findings include: On 7/11/06 at 1:10 pm, the clean linen room on the 400 hallway had 2 cloth heel protectors stored on the floor of the room. One heel protector was blue in color and the other was a plaid colored material. On 7/12/06 at 6:50 am, the same 2 heel protectors remained stored on the floor of the 400 hall linen room.	F 445		
F 456 SS=E	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by:	F 456		

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F 456	Continued From page 65 Based on observations and staff interview it was determined the facility did not ensure the boiler was appropriately inspected. This affected 1 of 13 (#5) sampled residents and all other residents who resided on the 300 hall. The findings include: On 7/13/06 at 9:00 am, the boiler located in the mechanical room on the 300 hall was observed to be last inspected on 8/25/03. According to the "Certificate Of Inspection," the next inspection was due 8/25/04. The certificate indicated the next inspection was to be an external. On 7/13/06 at approximately 9:05 am, the maintenance man stated, "I called and told them [the corporation] that the certificate was out of date." The maintenance man concurred the boiler required routine inspecting.	F 456	**F455 Continued from page 65** In-service all staff to place linen that falls on the floor into the dirty linen receptacles immediately, to prevent the possibility of the spread of infection. Also shelves will be built with a lip to ensure that linen will not fall on to the floor. Housekeeping staff to ensure this issue is resolved will do weekly audits of all linen rooms. **F445 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Review weekly at quality assurance meeting.	
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined the facility did not ensure that the emergency call lights in the tub/shower rooms on 3 of the 4 halls were easily accessible to residents and/or caregivers. This affected 9 of 13 (#1, 2, 3, 5, 6, 7,10,11, & 12) sampled residents and all other residents who resided on the 200, 300 and 400 halls. The findings include:	F 463	Person Responsible: Danielle Frasier, Housekeeping Supervisor. Completion Date: August 18,2006 OK, BF, 8/15/06 **456 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** An inspector certified the boiler. **F456 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents have the potential to be affected.	

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F 463	Continued From page 66 On 7/11/06 at 1:45 pm, the 200 hall shower room was observed to have one emergency call light located next to the toilet. There was a short chain, approximately 6 inches long, attached to the activation switch for the emergency call light. Any resident sitting on the toilet would have to reach out to try and reach the short chain. When shown to the maintenance man, he stated, "I can fix that." Across the room was the walk-in shower. There was no emergency call light in the near vicinity to the shower. If an resident and/or caregiver needed assistance from the shower, they would have to walk out and go over to the toilet to activate the emergency call light. The maintenance man concurred that the lack of an accessible emergency call system to the shower could pose a problem. He stated, "I can extend a cord over to the shower." Similar observations were made in the 300 hall shower room, and 2 shower rooms on the 400 hall. On 7/12/06 at approximately 7:15 am, the maintenance man stated he thought the cords would only be a temporary fix. He stated, "they work for now, I tried them out with the CNAs." The maintenance man indicated that he planned to contact a contractor and have more emergency lights installed in the tub/shower rooms.	F 463	**F456 Continued from page 66.** **F456 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Standing appointment will be made for an annual inspection **F456 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Reviewed yearly at safety meeting. Person Responsible: Boyd Stokes Maintenance Director Completion Date: August 18, 2006 **F463 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** Identified problem was fixed immediately. **F463 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents have the potential to be affected.	OK BF 8/15/06

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F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility did not ensure clinical records were complete and accurate. This affected 5 of 13 sample residents (#3, 7, 9, 10, & 11). Findings include: 1. Resident # 7 was originally admitted to the facility on 11/22/99 and readmitted on 8/31/02 with diagnoses including dementia, hypertension, joint pain, lumbago, psychosis, pulmonary congestion, glaucoma, atrial fibrillation, hypothyroidism, adjustment reaction prolonged depression and anxiety. a. The resident's bath records for April and May of 2006 were reviewed. The resident was to receive one shower per week and her bath day was Saturday. Documentation identified the resident received a shower on 4/22; there was no other documentation for the month of April. If given, a shower should have been documented on 4/29/06. The first shower documented for the	F 514	**F463 Continued from page 67.** **F463 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Contractor contacted about the installation a new call system in each shower room. Creating additional emergency call lights stations, which will be more accessible to staff and residents. **F463 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Reviewed monthly at safety meeting to ensure safety. Person Responsible: Boyd Stokes, Maintenance Director Completion Date: August 18,2006 OK, BF, 8/15/06 **F514 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** Resident (#3,7,9,10,11) was showered and received oral care. Staff was in-serviced on the importance of documentation.	

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F 514	Continued From page 68 month of May was identified as 5/9/06. If given, the a shower should have been documented on 5/6/06. b. The resident's CNA flow sheet for March 2006 was reviewed. The flow sheet indicated the resident was to receive oral care 4 times per day at 6:30 am, 9:30 am, 1:00 pm, and at hour of sleep. There was no documentation to indicate the resident was provided oral care at 9:30 am on March 1 through the 8th, the 10th, 11th, 12th, and the 17th through the 30th. There was no documentation to indicate if the resident was provided oral care at 1:00 pm on March 2, 9, 10, 13, 15, 16, 19, 21, 22, 29, and 30. There was no documentation to indicate the resident received oral care at hour of sleep from March 2nd through the 20th and the 22nd through the 30th. The resident's CNA flow sheet for May 2006 was reviewed. There was no documentation to indicate the resident was provided oral care at 9:30 am on May 12th through the 16th, the 18th through the 21st, and the 23rd through the 28th. There was no documentation to indicate the resident was provided oral care at 1:00 pm on May 4, 6, 21, 22, 23, 24, 25, 28, and 30. There was no documentation to indicate the resident was provided oral care at the hour of sleep on May 6, 15, 16, 17, 22, 23, 25, 27, 29, and 30. c. The resident's meal monitors for the months of March, April, May, and June 2006 were reviewed. *March 2006 - There was no record of food or fluid consumption for breakfast on March 25, 26, 29, and 30. The documentation was incomplete for lunch on 3/25 and 3/26, and for dinner on 3/2,	F 514	**F514 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents have the potential to be affected. **F514 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** All staff in-serviced on the importance of bathing, oral care, and the documentation of meals. The activities of daily living records will go to the daily report at every shift change were the nurse supervisor must check to ensure that no documentation is missing. Nurse supervisor is to monitor residents at mealtime and ensure that meal alternates are offered if the less that 50% of the meal is eaten. The dietary manager will complete random audits for compliance.	

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F 514	Continued From page 69 3/26, and 3/29. The form contained the instructions to offer an alternate to a resident if he or she consumed less than 75% of a meal. The documentation was incomplete regarding whether or not an alternate was offered and/or refused for 54 of 82 meals. *April 2006 - There was no record of food or fluid consumption for the resident on 4/30 (breakfast) and 4/26 (lunch). The documentation was incomplete regarding whether or not an alternate was offered and/or refused for 43 of 88 meals. *May 2006 - There was no record of food or fluid consumption for the resident on 5/25 (breakfast), 5/12, 22, 25, and 26 (lunch), and 5/1 (dinner). The documentation was incomplete regarding whether or not an alternate was offered and/or refused for 70 of 87 meals. *June 2006 - There was no record of food or fluid consumption for the resident on 6/12, 6/20 (breakfast), 6/1, 6/5, 6/8, 6/9, 6/12, 6/20, 6/23, 6/24 (lunch), and 6/6, 6/17, 6/20, and 6/25 (dinner). The documentation was incomplete regarding whether or not an alternate was offered and/or refused for 53 of 74 meals. Two CNAs who regularly worked with the resident were interviewed on 7/13/06 at 10:40 am regarding the resident's oral care. Both stated the resident was receiving oral care as scheduled and that it was a documentation issue. One CNA stated, "...I'm obsessive about getting her oral care done...I just forget to chart it..." The DON was also present during the interview. She stated that she and another staff member "...do bath audits weekly..." to ensure residents are bathed	F 514	**F514 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Will review weekly at quality assurance meeting. Person Responsible: Melodie Jensen, RN DNS and appointed designee. Cindy Broome, Dietary Manager Completion Date: August 18,2006 OK, BF, 8/15/06	

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F 514	Continued From page 70 according to their care plans. 2. Resident # 10 was originally admitted to the facility on 12/11/03 and readmitted on 2/9/06 with diagnoses including femur fracture, diabetes mellitus, hypertension, asthma, late-effect CVA [Cerebral Vascular Accident], dysphagia, osteoporosis, congestive heart failure, history of falls, and adjustment reaction prolonged depression. The resident's meal monitors for the months of March, April, May, and June 2006 were reviewed. *March 2006 - The documentation was incomplete regarding whether or not an alternate was offered and/or refused for 11 of 92 meals. *April 2006 - The documentation was incomplete regarding whether or not an alternate was offered and/or refused for 32 of 83 meals. *May 2006 - The documentation was incomplete regarding whether or not an alternate was offered and/or refused for 23 of 83 meals. *June 2006 - The documentation was incomplete regarding whether or not an alternate was offered and/or refused for 15 of 87 meals. On 7/13/06 at 9:35 am, the Dietary Manager was interviewed regarding specific dietary issues. She stated she would monitor the documentation on the meal monitors to ensure completeness.	F 514		

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F 514	Continued From page 71 3. Resident #3 was originally admitted to the facility on 10/21/98 and readmitted on 4/02/99, with diagnoses of status post fractured left hip, dementia and arthritis. The care plan dated 11/29/04, indicated the resident had been identified with the problem of a self care deficit related to disease processes including the arthritis and dementia. An approach to the problem stated, "13) Long term care restorative nursing walk to dine program." On 7/12/06 from 8:00 am to 8:10 am, the resident was observed being ambulated to the toilet in her room. A CNA was providing stand by assistance and the resident was using a walker. When asked about the walk to dine program the CNA stated, "a lot of the time she refuses to do it because of the pain." The CNA flow sheets for the months of March, April, May, June, and July of 2006 indicated that several days had no documentation to indicate if the restorative walk to dine was done or if the resident had refused. During the month of March of 2006, the walk to dine restorative therapy was not documented for 15 of the 31 days. During the month of April 2006, the walk to dine therapy was not documented for 10 of the 30 days. During the month of May of 2006, there was only 1 of the 31 days when the walk to dine was not documented. During the month of June of 2006, 10 of the 30 days were not documented for the walk to dine therapy. For the 11 days of July 2006, only the first 5 days had documentation to indicate if the resident participated in the walk to dine therapy or refused.	F 514		

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F 514	Continued From page 72	F 514		

4. Resident #11 was admitted to the facility on 1/20/06 and readmitted on 2/03/06, with diagnoses of multiple sclerosis and open reduction and internal fixation of the right humeral shaft (arm).

The care plan dated 2/21/06, indicated the resident had been identified with the problem of self care deficit. One of the approaches was for half side rails on both sides of the bed for bed mobility and positioning.

The side rail assessment dated 2/03/06, indicated the side rails were needed for bed mobility due to weakness related to the fracture, multiple sclerosis and status post cerebral vascular accident with right sided weakness.

The follow up side rail review, dated 4/07/06, indicated the resident, when asked if the side rails should be removed, requested the side rails remain to assist with bed mobility and personal security.

On 7/13/06 at 8:30 am, a LN was asked if the resident used the side rails. The LN stated, "yes, she needs the side rails to move around in bed."

The CNA flow sheets indicated that for the months of June and July of 2006, there were several nights when the side rails were not documented with no indication if the side rails had been lowered.

During the month of June of 2006, the night shift did not document on the side rail for 19 of the 30 nights. The evening shift did not document for 2

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F 514	Continued From page 73 of the 30 evenings. During the month of July of 2006, the night shift did not document the use of the side rails for 7 of the 12 nights. On 7/13/06 at approximately 9:40 am, the DON was interviewed about the documentation. The DON concurred that there were lapses in some of the documentation. The DON stated, "we need to follow through with documenting what is on the care plans." 5. Resident #9 was admitted on 4/6/04 with diagnoses that included Parkinson's disease, diabetes and congestive heart failure. Resident #9 was observed on 7/11/06 at 8:05 am during breakfast. She was seated at an assist table and a CNA-1 was feeding her. The CNA gave her a bite and the resident appeared to start choking. The CNA-1 called for a nurse who took her out of the dining room. The nurse told another CNA-2 to please take the resident to her room as she was not feeling well. The resident was holding a napkin to her mouth and gagging. The resident was assisted to her room by the CNA-s. The nurse then went to the room. She was talking to another CNA-3 outside by the door who was telling her the resident had diarrhea in the morning. The nurse then went into the room. When the nurse came out of the resident's room she said, "She is OK." The surveyor asked what was wrong and the nurse said, "She was just a little nauseated." The nurse then left. The resident was observed sitting in her wheel chair with an emesis pan in her lap and the call light on her lap. She looked as if she was falling asleep.	F 514		

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F 514	Continued From page 74 Nurse progress notes, dated 7/9/06, documented an elevated temperature of "... 99.5 day nurse notified." There was no nurse notes after that date. The surveyor asked for copies from the resident's record on 7/12/06 and no other nurses' notes were documented in the record. The facility had not documented an assessment of the resident who had presented with an elevated temperature on 7/9 and had diarrhea and nausea on 7/11/06.	F 514		

Bureau of Facility Standards

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C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual State licensure survey of your facility. The surveyors conducting the survey were: Barb Franek, RN, COHN-S Loran Bouse, LSW Diane Miller, LCSW Lisa Kaiser, RN Survey Definitions: MDS = Minimum Data Set assessment RAP = Resident Assessment Protocol RAI = Resident Assessment Instrument DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	C 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Twin Falls Care Center does not admit that the deficiencies listed on State Form 6899 exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal and/or regulatory or administrative proceedings all deficiencies, statements, facts, and conclusions that form the basis for each deficiency." RECEIVED AUG 09 2006 FACILITY STANDARDS	
C 117	02.100,03,c,i i. Is fully informed, as evidenced by the patient's/resident's written acknowledgement, prior to or at the time of admission and during his stay, of these rights and of all rules, regulations and minimum standards governing patient/resident conduct and responsibilities. Should the patient/resident be medically or legally unable to understand these rights, the patient's/resident's guardian or responsible person (not an	C 117	**See plan of correction for F167.**	

Administrator 8-8-6

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C 117	Continued From page 1 employee of the facility) has been informed on the patient's/resident's behalf; This Rule is not met as evidenced by: Refer to F167 as it related to the most recent Life Safety Code survey not being posted.	C 117		
C 125	02.100,03,c,ix ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F241 as it related to resident dignity.	C 125	**See plan of correction for F241.**	
C 175	02.100,12,f f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Refer to F225 as it related to incident/accident investigations.	C 175	**See plan of correction for F225.**	
C 259	02.106,07,g g. Each pressure vessel shall have a certificate of annual inspection which shall be posted adjacent to the vessel. This Rule is not met as evidenced by: Refer to F456 as it related to the boiler being past due for the inspections.	C 259	**See plan of correction for F456.**	

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C 317	Continued From page 2	C 317	**See plan of correction for F366.**	
C 317	02.107,07,d d. If a patient/resident refuses the food served, appropriate substitutes shall be offered. This Rule is not met as evidenced by: Refer to F366 as it related to dietary meal alternatives.	C 317		
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Based on observation and staff interview, the facility did not ensure sanitary conditions were maintained in the following areas: 1) food was stored under unsanitary conditions in the refrigerator in the activities room. This had the potential to affect 100 % of the residents who participated in activities in the facility including 13 of 13 sampled residents (#1-13). Findings include: On 7/11/06 at 2:05 pm, the refrigerator in the activity room that was for resident use, was observed to have a sandwich wrapped in tin foil, a plastic bag of grapes, and a plastic bag containing a partial brick of cheese. None of these food items were dated. An activity aide stated, "the dietary staff don't take care of this refrigerator, we do." The activity aide was not sure how long the food items had been in	C 325	**C325 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** All food items were disposed of that did not have a date. **C325 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents have the potential to be affected. **C325 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** In-service all staff that the refrigerator in activities is not for personal items.	

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C 325	Continued From page 3 the refrigerator.	C 325	**Continued from page 4.** C325 ~~F255~~ **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Review weekly at quality assurance meeting until compliant. After compliance audits will be done as needed. **Persons Responsible:** Patty Hutchenson, Activities Director Completion Date: Aug 18, 2006 OK, BF, 8/15/06	
C 342	02.108,04,b,ii ii. All toxic chemicals shall be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Refer to F323 as it related to shampoo/body wash in an unsecured shower room on the 300 hallway.	C 342		
C 393	02.120,04,b b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Refer to F246 as it related to call lights in the rooms not being accessible to residents. Refer to F463 as it related to call lights not being accessible to residents in the tub/shower rooms.	C 393	**See plan of correction for F323.**	
C 669	02.150,03 PATIENT/RESIDENT PROTECTION 03. Patient/Resident Protection.	C 669	**See plan of correction for F246**	

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TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301 **See plan of correction for F444**

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C 669	Continued From page 4 There is evidence of infection control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Refer to F444 as it related to improper hand hygiene.	C 669	See POC for F444	
C 671	02.150,03,b b. Proper handling of dressings, linens and food, etc., by staff. This Rule is not met as evidenced by: Refer to F445 as it related to clean heel protectors stored on the floor of the linen room.	C 671	**See plan of correction for F445.**	
C 778	02.200,03,a PATIENT/RESIDENT CARE 03. Patient/Resident Care. a. A patient/resident plan of care shall be developed in writing upon admission of the patient/resident, which shall be: This Rule is not met as evidenced by: Refer to F279 as it related to resident assessments.	C 778	**See plan of correction for F279.**	
C 779	02.200,03,a,i i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Refer to F272 as it related to assessments.	C 779	**See plan of correction for F272.**	

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C 782	Continued From page 5	C 782		
C 782	02.200,03,a,iv iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F-280 as it refers to the facility's failure to review and revise resident care plans.	C 782	**See plan of correction for F280**	
C 789	02.200,03,b,v v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 as it related to pressure ulcer care and prevention.	C 789	**See plan of correction for F314**	
C 790	02.200,03,b,vi vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 as it related to a potential slip/trip/fall hazard in an unsecured shower room on the 300 hallway. Refer to F324 as it related to supervision and accident prevention.	C 790	**See plan of correction for F324**	
C 879	02.203 PATIENT/RESIDENT RECORDS 203. PATIENT/RESIDENT RECORDS. The facility maintains medical records	C 879		

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C 879	Continued From page 6 for all patients/residents in accordance with accepted professional standards and practices. This Rule is not met as evidenced by: Refer to F514 as it related accuracy of documentation.	C 879	**See plan of correction for F514**	